**Eastern Band of Cherokee Indians Public Health and Human Services Division**
**&**
**Cherokee Indian Hospital Authority**

# VACCINE ATTESTATION FORM

I acknowledge that as a patient of Cherokee Indian Hospital Authority, I am responsible for ensuring that the information I am providing is accurate and true.

I attest that I have received a COVID-19 Vaccine and the vaccination card/record has not been falsified by myself, any organization, or other individuals.

I understand that if my vaccination card/record has been falsified, that Cherokee Indian Hospital Authority will remove my designation of "Vaccinated" from my medical record.

IF it is found that an individual has falsified any information to obtain winnings from Vax Cash promotion, that individual will forfeit any and all winnings.

**Cherokee Indian Hospital Association Patient Name:**

**Date of Birth:**

**Address (Mailing)**:

**Physical Address**:

**Location of Vaccination Site**:

**Health Record #**:

**Patient Signature**:

**Date of Signature:**

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